U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 19 March 2007

CASE NO.: 2005-BLA-05691

In the Matter of

D.G., Surviving spouse of T.G.
Claimant

v.

MATTHEW MINING
Employer

and

KENTUCKY COAL PRODUCERS SELF-INSURANCE FUND
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

JOSEPH E. WOLFE, Esq.
For the Claimant

RODNEY E. BUTTERMORE, JR., Esq.
For the Employer

CHRISTIAN BARBER, Esq.
For the Director,
Office of Workers' Compensation Programs,
U.S. Dept. of Labor

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER DENYING SURVIVOR'S BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis acquired while working in the Nation's coal mines, or to the survivors of coal miners whose death was due to such pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs that may result from coal dust inhalation.

In March 2005, this case was referred to the Office of Administrative Law Judges for a formal hearing (DX 26). [1] Subsequently, on April 19, 2006, the case was assigned to me. The hearing was held before me in Harlan, Kentucky on August 23, 2006, at which time the parties had full opportunity to present evidence and argument. The Claimant did not testify at the hearing.

The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The following issues are presented for adjudication:[2]

1) Whether the designated responsible operator is properly named;
2) Whether the Miner suffered from pneumoconiosis;
3) Whether the pneumoconiosis arose out of coal mine employment; and
4) Whether the Miner died due to pneumoconiosis.

II. PROCEDURAL BACKGROUND

The Claimant filed this claim for benefits on December 29, 2003 (DX 2). On December 7, 2004, the District Director issued a proposed Decision and Order granting benefits to the Claimant, based on a determination that the Claimant established the conditions for entitlement to benefits (DX 22). The Employer requested a formal hearing in a letter dated December 21, 2004 (DX 23). On March 22, 2005, this matter was forwarded to the Office of Administrative Law Judges for a formal hearing and thereafter assigned to me (DX 26).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant is the widow of a Miner who died in November 2003, at age 71 (DX 9). The record demonstrates that the Miner worked in the coal mining industry for at least 25 years

[1] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T" refers to the transcript of the August 23, 2006 hearing.

[2] The parties withdrew the issues of timeliness; the Claimant's status as a dependent; and the issue of "miner" status, with post-1969 employment. The parties stipulated to a coal mine employment resulting in a length of exposure of 25 years (T. at 31-32).

as stipulated, and performed several different jobs including motorman and equipment operator (DX 1 at 252-253A, DX 5). The record indicates that the Claimant and the Miner were married in June of 1956 (DX 8), and that the Claimant has not remarried (DX 2; T. at 32-33). The Claimant has no minor children (DX 2). Prior to his death, the Miner submitted at least one Claim for benefits. His most recent claim was administratively denied in August 1990 (DX 1).

B. Designation of the Responsible Operator

Because this claim was filed under Part 718, liability is assessed against the most recent operator for which Claimant last worked for a cumulative period of one year with at least one working day occurring after December 31, 1969. §725.494. Cole v. East Kentucky Collieries, 20 B.L.R. 1-51 (1996); Director, OWCP v. Trace Fork Coal Co. [Matney], 67 F.3d 503 (4th Cir. 1995) rev'g in part sub. nom., Matney v. Trace Fork Coal Co., 17 B.L.R. 1-145 (1993). A successor operator can also be the responsible operator. See §725.492. Where no operator can be identified, liability for the payment of benefits lies with the Black Lung Disability Trust Fund (Trust Fund).

In this case, the record contains several exhibits concerning the Miner's coal mine employment (DX 3-7, see also Living Miner's claim (DX 1) at 11, 40-43, 225-228, 252-253A). The record includes W-2 forms from the Miner's employment for the years 1956 through 1986 (DX 6); the most recent W-2 forms are for "Matthew's Mining Company," and cover the period from 1983 through 1986 (DX 6). The W-2 forms for Matthew's Mining state that the Miner had the following earnings, rounded to the nearest dollar: 1983 – $2,996; 1984 – $350; 1985 – $7,410; 1986 – $2,380. The Miner's Social Security records reflect that the Miner worked for "Matthews Mining Co.," also called "Joseph C. Preece," during the period from 1983 through 1986; his earnings are reflected as the following, rounded to the nearest dollar: 1983 – $2,996; 1984 – $350; 1986 – $2,380. The Miner had no employment after 1986. I note that the earnings are similarly recorded; however, his Social Security records do not reflect work for Matthews Mining in 1985, while the W-2 forms do. The record also includes a letter from Consolidation Coal Company dated June 23, 1987, which states: "This will verify that [the Miner] was an employee of Consolidation Coal Company's Matthews Mine. . . . [The Miner] last worked on July 16, 1980" (DX 5). The Miner's Social Security records reflect that the Miner worked for Consolidation Coal from 1969 to 1980 (DX 6).

After examining the evidence of record, particularly the last several consecutive calendar years during which he worked for the Employer, I find that the evidence establishes that he worked for the Employer for a one year period. Given the general lack of accuracy in the file concerning the Claimant's employment history, particularly the fact that the Claimant's Social Security Records and W-2 forms show a substantial discrepancy (his 1985 earnings reflected in his W-2 forms are not listed on his Social Security records), and given that he worked for the Employer over the course of several consecutive years, I find that the Miner worked for the Employer for at least one calendar year.[3]

[3] In making my determination, I note that, while the Employer controverted that it was the responsible operator, it did not provide an argument or evidence in support of its controversion. I note also that the Employer, Matthews Mining Company, was the named responsible operator

Thus, the Employer employed the Miner for the one-year period required in §725.494, and employed the Claimant after 1969. The Employer meets the other criteria for being designated as the responsible operator. Based on the foregoing, I find that the Employer is the potentially liable operator that most recently employed the Miner. Consequently, I find that it was appropriately designated as the Responsible Operator in this matter, in accordance with §725.495, and that the Employer's designation is supported by the evidence of record.

C. Relevant Medical Evidence[4]

The Claimant submitted two X-ray readings in support of her Claim, which were performed by Dr. John Dineen and Dr. W. S. Cole (CX 1, 2, which are located in the Living Miner's claim, at page 109 and 206, respectively). In addition, the Claimant submitted medical reports from Dr. Joshua Perper and Dr. Glen Baker (CX 5, 6; CX 6 is located at page 208 [Claimant called this page 213, which is instead a X-ray interpretation] of the Living Miner's claim). The Claimant submitted a report of an autopsy performed by Dr. Syed Ally and Dr. N. R. Bathjia, and treatment records from Appalachian Regional Healthcare, which cover the period from November 1994 until November 2003 (DX 12, 21). Finally, the Claimant submitted the death certificate written by the Miner's treating physician, Dr. Claire Oculam; the death certificate lists the following: aortic valve replacement was listed as the underlying cause of death; failure to thrive was listed as the immediate cause of death; end stage dementia and multiple CVA were listed as causes leading to the Miner's failure to thrive (DX 9).[5]

The Employer submitted medical reports from Dr. Gregory Fino, and Dr. James Lockey, as well as the transcript taken of a deposition of Dr. Lockey (EX 1, 2, 6). In addition, the Employer submitted an autopsy report prepared by Dr. Paul Biddinger (EX 3). The Employer also submitted X-ray interpretations by Dr. Jerome Wiot and Dr. William Scott (EX 7, 8).

Finally, the parties submitted hospital records from Middlesboro ARH, which cover the period from 1994 until the Miner's death in 2003 (DX 12, 21).

D. Entitlement

The Act provides for benefits to eligible survivors of deceased miners whose death was due to pneumoconiosis. §718.205(a). Eligible claimants may include a miner's widowed spouse. §725.201(a)(2). Under §718.205, where there is no miner's claim filed prior to January 1, 1982 resulting in entitlement to benefits, a survivor who files a claim after January 1, 1982, as

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in the living miner's claim (DX 1). I also note there is some evidence that the Employer may be a successor operator.

[4] As discussed at the hearing, I considered the evidence from the living miner's claim, except for medical evidence, which due to evidentiary limits, I considered only if proffered by a party.

[5] The Claimant also submitted two blood gas studies performed by Dr. Dineen and Dr. Broudy (CX 3, 4, which are located in the Living Miner's claim, at page 112 and 172, respectively). However, as this is a survivor's claim, not a living miner's claim, the Miner's disability is not at issue. Therefore, blood gas studies are not relevant to entitlement, and I will not discuss them.

in this case, is entitled to benefits only upon demonstrating that the Miner died due to pneumoconiosis.

In a survivor's claim, it must first be determined whether the miner suffered from coal workers' pneumoconiosis before a finding may be made regarding the etiology of his death. Trumbo v. Reading Anthracite Co.,17 B.L.R. 1-85 (1993). In order to establish entitlement to benefits in a survivor's claim filed on or after January 1, 1982, therefore, a claimant must establish three elements by a preponderance of the evidence: (1) that the miner had pneumoconiosis; (2) that the miner's pneumoconiosis arose out of coal mine employment; and (3) that the miner's death was due to pneumoconiosis. §718.205(a)(1) through (3). Trumbo v. Reading Anthracite Co., 17 B.L.R. 1-85 (1993). The Claimant has the burden to establish each element of entitlement. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

1. Whether the Miner had Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§718.202(a)(1) through (a)(4):

(1) X-ray evidence: §718.202(a)(1).
(2) Biopsy or autopsy evidence: §718.202(a)(2).
(3) Regulatory presumptions: §718.202(a)(3).[6]
(4) Physician opinion based upon objective medical evidence: §718.202(a)(4).

X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with §718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3 A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis. Category 1/0 is ILO Classification 1.

The current record contains the following chest X-ray evidence:

[6] These are as follows: (a) an irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§718.306).

Date of X-Ray	Date Read	Ex.No.	Physician	Radiological Credentials[7]	Interpretation
02/19/1987	04/15/1987	CX 2	Cole	BCR, B	1/1; q, s; all six lung zones Cardiac Enlargement
02/19/1987	09/05/1987	EX 7	Wiot	BCR, B	Negative
04/27/1988	05/09/1988	CX 1	Dineen	Not of record	1/0; p, p; left and right center lung zones
04/27/1988	07/28/1988	EX 8	Scott	BCR, B	Negative Cardiomegaly—CTR 15/28.5 Hyperinflation lungs – cannot r/o emphysema Surgery near GE junction

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984).

The record contains two X-rays, both of which were read once as negative for pneumoconiosis, and once as positive for pneumoconiosis. The first X-ray was read as positive by Dr. Cole, and negative by Dr. Wiot; both physicians are equally qualified, as they are both Board certified radiologists and B readers. Therefore, I find their readings of equal value. Regarding the second X-ray, it was read as positive by Dr. Dineen, and negative by Dr. Scott. However, Dr. Dineen's qualifications are not of record, while Dr. Scott is a Board certified radiologist and B reader. Therefore, I give more weight to Dr. Scott's opinion that this X-ray is negative for pneumoconiosis.

[7] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology #after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. §37.51 for a general description of the B reader program.

In sum, therefore, one X-ray is inconclusive, and the other is negative for pneumoconiosis, and I find that the X-ray evidence does not establish pneumoconiosis. Thus, I find that the Claimant has not carried her burden of proof to establish, by a preponderance of evidence, that the Miner had pneumoconiosis by means of X-ray. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. §718.202(a)(2). Quality standards for autopsies and biopsies are set forth at §718.106. A physician's review of pathology tissue slides may constitute an autopsy report. Keener v. Peerless Eagle Coal Co., BRB No. 05-1008 BLA (Jan. 26, 2007). The record includes reports of two autopsies, one performed by Syed Ally and Dr. N. R. Bathjia (DX 12), and the other performed by Dr. Paul Biddinger (EX 3).

Dr. Syed Ally & Dr. N. R. Bathjia (DX 12)

The Claimant submitted the report from a chest autopsy performed by Dr. Ally; the autopsy was performed on November 18, 2003. Underneath Dr. Ally's signature line on his autopsy report, his title is listed as "Pathologist" (DX 12 at 13). On November 19, 2003, Dr. Ally dictated an autopsy limited to the Miner's chest only, and made the following provisional anatomic diagnoses: 1) Pulmonary edema and congestion, extensive, bilateral; 2) Pulmonary emphysema, bilateral; 3) coal worker's (sic) pneumoconiosis, lungs, bilateral, simple 4) Left ventricular hypertrophy, heart (415 grams); 5) Hilar lymph nodes, anthracotic changes; 6) Atherosclerosis with focal calcifications, moderate to severe, involving coronary arteries, left anterior descending, left and right coronaries and aorta; 7) status post aortic valve replacement; 8) Pleural adhesions, fibrous, focal, bilateral (DX 12 at 13).

The Claimant also submitted a report of a chest autopsy by Dr. Bathjia, also performed on November 18, 2003. Underneath Dr. Bathjia's signature line on his autopsy report, his title is listed as "Pathologist" (DX 12 at 16). Dr. Bathjia dictated his report on December 12, 2003. His final anatomic diagnoses were 1) bronchopneumonia, lungs bilateral, lower lobes; 2) Pulmonary edema and congestion, extensive, bilateral; 3) Pulmonary emphysema, bilateral; 4) Coal worker's (sic) pneumoconiosis, lungs, bilateral, typical micronodular; 5) Left ventricular hypertrophy, heart (415 grams); 6) Hilar lymph nodes, enlarged, fibrosis in deposition of anthraco-cilia particles, nodular; 7) Atherosclerosis with focal calcifications, moderate to severe, coronary arteries and aorta; 8) Status post aortic valve replacement; 9) Pleural adhesions, fibrous, focal, bilateral, especially upper lobes (DX 12 at 16). Dr. Bathjia's report states, in pertinent part, that the Miner's chest appeared as follows:

> MICROSCOPIC: RESPIRATORY SYSTEM
> The sections of lungs show focal serosal adhesions especially right and left upper lobe. The lungs in the lower lobe show bronchopneumonia alveoli, distended with polymorphonuclear leukocytes, few lymphocytes, plasma cells. The last addition shows emphysema, especially upper lobes. Focal atelectasis, bronchitis, with simple and micronodular type of coal worker's

> (sic) pneumoconiosis. The lungs show deposition of anthracotic and silica particles surrounding the bronchi, pulmonary vessels and alveoli. In many areas there are micronodules with hyalinization, focal calcifications. The hilar lymph nodes are enlarged showing follicular hyperplasia with deposition of anthraco-silica particles, fibrosis (DX 12 at 17).
>
> INTERNAL EXAMINATION: RESPIRATORY SYSTEM
> The left and right lungs are slightly heavy, edematous, boggy, weighing approximately 550 and 750 grams respectively. The lungs bilaterally show pinkish-tan to grayish-white to focally mottled blackish discoloration on the pleural surfaces. Sections of both lungs show presence of emphysematous changes which are more prominent in the upper lobes bilaterally. Sectioning also shows extensive pulmonary edema with frothy fluid coming out from the cut surfaces. Pulmonary congestion is also present bilaterally and is more prominent in the lower lobes. The possibility of bronchopneumonia has to be checked microscopically. No nodules are identifiable. The hilar lymph nodes show anthracotic changes. No tumor is identifiable. The tracheobronchial passages are patent. No pulmonary emboli is identifiable. The pleural surfaces show focal areas of fibrous adhesions bilaterally. However, the lungs could be easily separated from the parietal pleura on both sides.

Dr. Paul Biddinger (EX 3)[8]

The Employer submitted an autopsy report written by Dr. Paul Biddinger.[9] Dr. Biddinger is Board-certified as a medical examiner, and as a pathologist, with subspecialties in anatomic and clinical pathology, and forensic pathology.

Dr. Biddinger reviewed slides and pathology reports related to the Miner. Based on his review of the slides, Dr. Biddinger stated:

> Review of the lung slides reveals features characteristic of simple coal workers' pneumoconiosis (CWP). Scattered throughout the lungs are macules and nodules characteristic of CWP. In addition to the black coal pigment, birefringent particles consistent with silica and silicates are also evident in the macules and nodules. In some of these lesions, the fibrous tissue forms rounded silicotic type nodules. These silicotic type

[8] During Dr. Lockey's deposition, the attorneys for the Parties refer to Dr. Biddinger's report as EX 2 (See EX 6 at 8). However, at the hearing, and in the Employer's pre-hearing statement, the Biddinger report was designated EX 3. Therefore, throughout this decision, I refer to the Biddinger report as EX 3.

[9] The report in question is submitted on University of Cincinnati letterhead, and signed by Dr. Paul Biddinger. However, the name typed on the heading of the letter is that of Dr. James Lockey. It appears that, based on the signature, the letter was written by Dr. Biddinger.

> nodules are also evident in the sections of lymph nodes. Features of complicated CWP, progressive massive fibrosis, are not present.
>
> The lung tissue also exhibits features of acute bronchopneumonia. Alveolar spaces and bronchioles in sections from the right lower, right middle and left lower lobes contain inflammatory exudates predominately composed of neutrophils. The etiology is not entirely clear, but most likely represents a bacterial infection superimposed on the underlying CWP.
>
> In summary, the sections of lung exhibit features of simple coal workers' pneumoconiosis. The specific role of this disease in [the Miner's] death is difficult for me to state based only on the review of the slides.

The record contains three pathology reports, all of which report findings consistent with pneumoconiosis. All three physicians gave a thorough explanation and description of their findings, and all of the reports were well-written. As all three physicians are in consensus, I find that the autopsy and pathology evidence is demonstrative of pneumoconiosis. Therefore, I find that the Claimant has established the existence of pneumoconiosis through autopsy.

Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Since none of these presumptions applies in this case, the existence of pneumoconiosis has not been established under §718.202(a)(3).

Physician Opinion

The fourth way to establish the existence of pneumoconiosis under §718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination,

symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

The record contains the following medical opinions:

Dr. Joshua Perper (CX 5)

The Claimant submitted a report written by Dr. Perper, who is Board certified in anatomical and surgical pathology, as well as forensic pathology. Dr. Perper reviewed several records including the death certificate, autopsy report from Dr. Bathjia, medical records from Appalachian Regional Healthcare, a summary of an examination of the Miner performed by Dr. Robert Penman, medical records from the OWCP, as well as pulmonary consultation reports and related diagnostic testing from 1987 and 1988, and a medical opinion report written by Dr. Patel in 2004. Also, he summarized the various descriptions of the Miner's occupational and smoking histories compiled from the evidence before him. Before writing his conclusions on the Miner's status, he summarized the Miner's medical treatment records in great detail.

After reviewing the evidence discussed above, Dr. Perper gave his opinion on the issue of whether the Miner had coal workers' pneumoconiosis, and the severity of such disease. He found that the Miner had a coal mine history of more than 31 years, which was largely underground work. He listed the Miner's reported symptoms relevant to pneumoconiosis, such as "worsening shortness of breath, cough with expectoration of mucus, decreased breath sounds with wheezing and rhonchi, combined obstructive and restrictive pulmonary disease, hypoxemia and respiratory failure that required treatment with bronchodilators, steroids and ultimately with supplemental oxygen." He noted that "some of the radiological reports did not diagnose coal workers' pneumoconiosis or nodularities," but he stated that "simple coal workers' pneumoconiosis, especially of the interstitial fibrosis type is often missed by radiologists, and interpreted as COPD or non-specific interstitial fibrosis." Dr. Perper also noted that "autopsy findings, the golden standard for diagnosing coal workers' pneumoconiosis substantiated the presence of severe coal workers (sic) pneumoconiosis of the macular, nodular and interstitital fibrosis type with associated severe centrilobular emphysema." In sum, he concluded that the Miner did have COPD and pneumoconiosis, and that the "autopsy findings revealed severe coal workers (sic) pneumoconiosis." Dr. Perper stated that there is a recognized pattern that demonstrates interstitial pulmonary fibrosis consistent with coal workers' pneumoconiosis, and he found that the Miner displayed such a pattern. He opined that coal workers' pneumoconiosis may progress after a cessation of occupational exposure to coal dust, and cited supporting studies.

Concerning whether the Miner had emphysema attributable to coal dust exposure, Dr. Perper affirmed that "exposure to mixed coal dust containing silica or coal workers' pneumoconiosis [is] known to cause centrilobular emphysema in general," as well as in the particular case of the Miner. Dr. Perper stated:

> It is true that centrilobular emphysema is a known complication of smoking and [the Miner] was a substantial heavy smoker and therefore one cannot but affirm that his pulmonary emphysema was attributed in significant part to his smoking. However, as

> abundantly substantiated reliable scientific literature in the last decades, centrilobular emphysema is also a direct result of exposure to mixed coalmine containing silica and coal workers' pneumoconiosis. While it is legitimate to recognize in general the role of smoking in producing centrilobular emphysema, it is equally legitimate to recognize the significant role of exposure to coal mine dust and coal workers' pneumoconiosis, and there is no logical reason to exclude it.

Dr. Glen Baker (CX 6)

The Claimant submitted a report from Dr. Baker that was written in conjunction with the Miner's OWCP evaluation, performed in February 1987, as part of the living miner's claim.[10] Dr. Baker's credentials are not of record. Dr. Baker recorded that the Miner had a coal mine employment history that ranged from 1956 until 1986; he recorded that the Miner "worked on cutting machines, shuttle car and track motor." He also recorded that the Miner had a smoking history of one-half to a pack and a half per day for 40 years.

Dr. Baker noted that the Miner related the following health history: pneumonia, wheezing, chronic bronchitis, arthritis, cancer. At that time, his present illness included cough, sputum, wheezing, dyspnea, chest pain, orthopnea. Upon physical examination, Dr. Baker noted abnormal findings in the Miner's neck arteries, peripheral pulse, and heart murmurs.

Dr. Baker made the following diagnoses: "chronic obstructive pulmonary disease, chronic bronchitis, (illegible), chest pain (?) etiology, ? left hilar bases, arteriosclerosis and (illegible)." The basis for his diagnosis was "symptoms, duration of employment, abnormal chest X-ray" (DX 1 at 208).

Dr. Gregory Fino (EX 1)

The Employer submitted a report that Dr. Fino wrote in January 2005. Dr. Fino is Board certified in internal medicine, with a subspecialty in pulmonary disease; he is also a certified B reader. Dr. Fino's report contained his review and critique of several medical records, as well as his discussion and conclusion of the Miner's health and cause of death. He also listed the various reported occupational and smoking histories. Dr. Fino discussed whether the Claimant had coal workers' pneumoconiosis, or any respiratory or pulmonary impairment due to coal dust exposure, by stating the following:

> The only evidence of coal workers' pneumoconiosis is the autopsy that was limited to the chest which described micronodular coal workers' pneumoconiosis. It is, therefore, reasonable to assume that pathologic pneumoconiosis was present.

[10] I note that the Baker report was written 20 years ago. However, as pneumoconiosis is a progressive disease, the age of the report does not diminish its value.

> In reviewing the numerous hospitalizations and other medical encounters of this patient, it is clear that he had chronic obstructive pulmonary disease (COPD) and numerous other medical problems contributing to his overall poor health. I am aware that he had [a] smoking history as high as 150 pack years and also worked between 32 and 40 years in the mining industry. . . .
>
> Also, when I look at all of the many medical records in this case, the patient was described as having chronic obstructive pulmonary disease (COPD) due to cigarette smoking, and numerous diagnoses of tobacco abuse and nicotine abuse were made. There were no diagnoses of a coal mine dust-related lung condition.
>
> Based on the information, I think that he was disabled due to lung disease and I believe that this lung disease was related to cigarette smoking. . . . Finally, I see no evidence that coal mine dust inhalation was a contributing factor in his pulmonary disability.

Dr. James Lockey (EX 2, 6)[11]

The Employer also submitted a physician opinion report from Dr. Lockey, written in September 2004, as well as a transcript of a deposition taken in August 2006 (EX 2, 6). Dr. Lockey is Board certified in internal medicine with subspecialties in pulmonary disease and occupational medicine; he is also a certified B reader (EX 6).

In writing his report, Dr. Lockey reviewed the Miner's medical records, including Dr. Biddinger's pathology report (EX 2). Concerning Dr. Biddinger's assessment, Dr. Lockey stated: "Dr. Biddinger felt the pathology findings were consistent with simple coal workers' pneumoconiosis. There was also evidence of acute bronchopneumonia with no features of complicated coal workers' pneumoconiosis or progressive massive fibrosis." Concerning the X-ray evidence, Dr. Lockey "noted based on the review of the medical records that there was no mention of any radiographic changes consistent with coal workers' pneumoconiosis or other type of occupational pulmonary disorder." Dr. Lockey made the following conclusions:

> Based on the medical information available, it is my opinion within a reasonable degree of medical probability and certainty that [the Miner] did not have clinical findings based on the available medical records of simple coal workers' pneumoconiosis nor did the chest radiographs reportedly demonstrate any changes consistent with simple coal workers' pneumoconiosis. It is noted that [the Miner] worked in the coal mining industry for approximately 40-years and the review of

[11] During Dr. Lockey's deposition, the attorneys for the Parties refer to Dr. Lockey's report as EX 3 (See EX 6 at 8). However, at the hearing, and in the Employer's pre-hearing statement, the Lockey report was designated EX 2. Therefore, throughout this decision, I refer to the Lockey report as EX 2.

> the pathology tissue demonstrated findings consistent with pathological evidence of simple coal workers' pneumoconiosis. This would not necessarily be unexpected in an individual who worked this length of time in the coal mining industry. The magnitude of the pathological changes within the lung were relatively minor, however, in that they were not of the magnitude to be associated with radiographic changes of pneumoconiosis. There was no significant pulmonary impairment or vocational disability as a result of the pathological findings of simple coal workers' pneumoconiosis. The primary cause of [the Miner's disability] was the recurrent cardio embolic events from the prosthetic aortic valve and the resultant recurrent multiple CVAs and subsequent dementia.

At deposition, Dr. Lockey reasserted his opinions on the Miner's condition. On direct examination, he stated that his opinion continued to be that the Miner "did not have clinical evidence, based on available medical records, of simple coal workers' pneumoconiosis." However, he noted that "the review of the pathology tissue did demonstrate pathological evidence of simple coal workers' pneumoconiosis, but this was to a minor degree, in that it was not clinically evident, at least based on available medical records. . . . So pathologically, it was present, but clinically, there was no clinical evidence of it being present." (EX 6 at 14). Further, Dr. Lockey stated:

> [I]n general, simple coal workers' pneumoconiosis, even when you diagnose it clinically, it is not associated with any significant impairment. It only becomes impairing when somebody goes on to develop progressive massive fibrosis or complicated coal workers' pneumoconiosis.
>
> In this particular case, clinically there was no evidence of coal workers pneumoconiosis in regard to that none of the examining physicians ever listed that as a diagnosis.
>
> But pathologically, which is a more sensitive technique than clinical evaluation, did find pathological findings of early simple coal workers' pneumoconiosis. This degree of pneumoconiosis that would be found pathologically, but not clinicically (sic), is not associated with any type of significant clinical inpairment (sic) (EX 6 at 15).

Finally, he stated "[i]f you get progressive massive fibrosis, it's obvious on a chest radiograph examination. And progressive massive fibrosis is associated with significant pulmonary impairment." He also affirmed that "severe interstidal (sic) micronodular type of pneumoconiosis is consistent with progressive massive fibrosis" (EX 6 at 16).

On cross examination, Dr. Lockey affirmed that he "said that first stage black lung is not significant, impairmentwise, unless it turns into progressive massive fibrosis" (EX 6 at 20).

Below, are some excerpts from Dr. Lockey's cross-examination:

Q: . . . You said that first stage black lung is not significant, impairmentwise, unless it turns into progressive massive fibrosis, is that correct?
A: That's correct. . . .
Q: Now, is it possible for a coal miner to have coal workers' pneumoconiosis that does not show on x-ray?
A: Yes. In fact, I think that was probably the case in this particular circumstance.
Q: Is it possible for a person to have complicated coal workers' pneumoconiosis that does not show up on x-ray?
A: No.
Q: Now . . . can simple coal workers' pneumoconiosis, as we have in this case, is that progressive?
A: With removal of exposure, simple coal workers' pneumoconiosis is not felt to be a progressive disease.
Q: So in the absence of continued coal mine employment, black lung is not progressive?
A: The simple form of black lung, that's correct.
Q: Okay. Now, can simple coal workers' pneumoconiosis first become apparent after coal mine employment ceases?
A: Again, it's usually not progressive after removal from exposure. So, I would say under most circumstances, if you leave employment and it's been pure coal dust exposure, most likely not. If there's a collateral silica exposure, then it can become more evident.
Q: Can coal mine employment cause emphysema?
A: It can cause . . . mild emphysema.
Q: Can coal mine employment cause bronchitis?
A: It can cause bronchitis, the type of bronchitis we call is industrial bronchitis.
Q: And can coal mine employment cause COPD?
A: To a mild extent it can, yes.
Q: And does coal workers' pneumoconiosis get better over time?
A: The industrial bronchitis gets better with removal from exposure. If the person has mild airway obstruction from a long history of coal dust exposure, that can slightly improve but it doesn't normally go back to normal baseline.
Q: Okay. Is coal workers' pneumoconiosis reversible?
A: No.
Q: Okay. Now, is it possible for both coal mine employment and smoking to contribute to emphysema?
A: Yes, yes. . . .
Q: Now, can simple coal workers' pneumoconiosis be totally disabling?
A: No. . . .
Q: . . . [I]f I were to ask you, did [the Miner] suffer from coal workers' pneumoconiosis, your answer to that

would be no?

A: No. He had pathological evidence of simple coal workers' pneumoconiosis. He did not have clinical evidence of that, but he did have pathological evidence of simple coal workers' pneumoconiosis.

(EX 6 at 22-26).

Treatment Records (DX 12, 21)

The record also includes about 300 pages of medical records from the Miner's treatment at Middlesboro ARH Hospital, and under the care of Dr. Claire Oculam. These notes cover the Miner's health care from the 1990's until the Miner's death in 2003, and mention several health issues such as emphysema, chronic airway obstruction, aspiration, anorexia, cardiomegaly, hyperlimpidemia, tobacco use disorder, COPD, multiple CVA, dementia, osteoporosis, hypertension, pneumonia, hypovolemia, gastroenteritis, esophageal stricture, reflux esophagitis, diaphragmatic hernia, dehydration, peptic ulcer, and abdominal pain; the Miner was also treated for a four-wheeler injury.

Discussion

The record contains three physician opinions positive for pneumoconiosis: Dr. Perper, a pathologist; Dr. Fino, a pulmonologist, and Dr. Baker, whose credentials are unknown. The record also includes one physician opinion negative for pneumoconiosis: Dr. Lockey, who is certified in pulmonary disease and occupational medicine, and treatment records.

I find that the opinions of Dr. Perper and Dr. Fino are well-reasoned, and well-documented, as both physicians gave a thorough explanation of their findings, and both gave reference to the sections of the record, particularly treatment records and pathology reports, that formed the basis for their opinions. Dr. Perper concluded that the Miner had both clinical and legal pneumoconiosis, as he attributed the Miner's emphysema, in part, to his coal mine employment, and he cited many studies for the premise that coal mine dust may cause emphysema. On the other hand, while Dr. Fino did not see evidence that the Miner's COPD was caused by coal mine dust, he did acknowledge the pathological evidence of pneumoconiosis.

I find Dr. Baker's opinion was reasoned and documented, as he based his opinion on his systematic physical examination of the Miner, particularly the Miner's symptoms, employment history, and abnormal X-ray. As discussed above, I did not find that the Miner's X-rays established pneumoconiosis, nor did I review Dr. Baker's X-ray interpretation. However, I find that his diagnoses were reasoned, as they followed logically from his findings.

I found that Dr. Lockey's opinion was not well reasoned based upon several questionable statements he made at deposition. Although some of his statements were in line with the intentions of the Act, in large part, his opinions were not reflective of the governing Act and its regulations. For example, he opined that black lung does not cause a significant impairment "unless it turns into progressive massive fibrosis;" that without continued exposure to coal dust, "simple coal workers' pneumoconiosis is not felt to be a progressive disease;" and that simple

coal workers' pneumoconiosis cannot be totally disabling. Therefore, in light of such statements, I give only little weight to Dr. Lockey's opinion on the issue of pneumoconiosis.

Based on the record, I find that the physician opinion demonstrates that the Miner had pneumoconiosis. Further, as discussed above, I found that the autopsy and pathology evidence established pneumoconiosis as well. In sum, therefore, I find that the Claimant has established, by a preponderance of the evidence, that the Miner had pneumoconiosis.

2. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. §718.203(b). However, where a miner has established less than ten years of coal mine employment history, "it shall be determined that such pneumoconiosis arose out of that employment only if competent evidence establishes such a relationship." §718.203(c). In this case, I found that the Claimant has established that the Miner had 25 years of coal mine employment, and that he is entitled to the presumption that his pneumoconiosis is due to coal mine employment. Therefore, I find that the Miner's pneumoconiosis arose out of his coal mine employment.

3. Whether the Miner's Death was Due to Pneumoconiosis

Benefits are provided under the Act for survivors of miners who died due to pneumoconiosis. §718.205. For claims filed on or after 1982, § 718.205(c) provides the criteria for determining whether a miner's death is due to pneumoconiosis. This section requires that the Claimant establish one of the following:

(1) competent medical evidence establishes that pneumoconiosis was the cause of the miner's death;

(2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or where the death was caused by complications of pneumoconiosis; or

(3) where the presumption of §718.304 [complicated pneumoconiosis] applies.

In this case, there is no evidence that the Miner had complicated pneumoconiosis, as set forth in §718.304. Therefore, §718.304 does not apply, and it cannot be presumed that the Miner's death was due to pneumoconiosis. Consequently, the Claimant bears the burden to establish that the Miner's death was due to pneumoconiosis, or that pneumoconiosis was a substantially contributing cause of the Miner's death.

The Miner's death certificate states that failure to thrive was the immediate cause of death; other causes leading to the immediate cause include end stage dementia and multiple CVA, and the underlying cause of death was listed as an aortic valve replacement. Pneumoconiosis was not listed as a cause of death on the death certificate, and none of the physicians who provided testimony concluded that pneumoconiosis was the sole cause of the

Miner's death, nor do any medical reports or treatment notes establish such. Therefore, I find that the Claimant is unable to establish an entitlement to benefits based on §718.205(c)(1).

The remaining subsection of §718.205(c) permits benefits to be paid if the Claimant establishes that pneumoconiosis is a "substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis." §718.205(c)(2). The regulation provides that pneumoconiosis is a substantially contributing cause if it hastens death. §718.205(c)(5). The regulation also cautions, however, that survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. §718.205(c)(4).

Dr. Joshua Perper (CX 5)

Concerning whether "severe coal workers' pneumoconiosis [was] a substantial contributory cause of [the Miner's] death, or a hastening factor in his death," Dr. Perper opined that it was, stating the following:

> Based on the pulmonary pathological findings indicative of severe interstitital and micronodular type of coal workers (sic) pneumoconiosis, and the occupational, smoking, and clinical documentation reviewed and discussed above, it is my professional opinion within a reasonable degree of medical certainty that there is competent medical evidence that coal workers' pneumoconiosis was a substantial cause of his pulmonary impairment and disability and ultimately contributed to and hastened his death. This determination is based on the following:
>
> 1) Symptomatic inability to perform because of shortness of breath, wheezing and other respiratory symptoms
> 2) Worsening of the miner's objective pulmonary clinical findings as presented above with combined restrictive obstructive defect, hypoxemia and CO2 (sic) retention
> 3) The documented presence of substantial and significant coal workers' pneumoconiosis at autopsy, with severe interstitial fibro-anthracosis.
> 4) The presence of causally associated centrilobular emphysema (in conjunction with smoking)

Dr. Gregory Fino (EX 1)

As stated above, Dr. Fino saw "no evidence that coal mine dust inhalation hastened this man's death." In pertinent part, he stated:

> There were no objective tests of lung function, although I suspect this man was disabled due to obstructive lung disease. Based on the information I reviewed, there is no evidence of lung disease playing

> a role in his death. The death certificate does not list any lung diseases and certainly the autopsy was not sufficient to exclude what would be the major causes of death in this man which would include another stroke, or possibly bleeding into his abdomen. Please recall that the autopsy was limited to the chest….
>
> Based on the information, I think that he was disabled due to lung disease and I believe that this lung disease was related to cigarette smoking. I see no evidence, whatsoever, that coal mine dust inhalation played a role in [the Miner's] lung disease. I see no evidence that coal mine dust inhalation hastened this man's death. Finally, I see no evidence that coal mine dust inhalation was a contributing factor in his pulmonary disability.

Dr. James Lockey (EX 2, 6)

Concerning the Miner's cause of death, Dr. Lockey stated:

> It is my opinion within a reasonable degree of medical probability and certainty that the existence of pathological evidence of simple coal workers' pneumoconiosis would not be considered a significant factor leading to [the Miner's] demise. [The Miner] had numerous medical problems of which the most significant was recurrent cardio embolic events as a result of a prosthetic aortic valve resulting in 3 to 4 cerebral vascular accidents. This resulted in dementia which in combination with his recurrent upper gastrointestinal problems of gastritis and esophagitis and associated aspiration as well life long history of cigarette smoking and associated COPD resulted in recurrent pneumonia. I am in agreement with the cause of death as listed in the death certificate.

(EX 2).

On re-direct examination, Dr. Lockey made the following statement, concerning whether simple pneumoconiosis caused or hastened the Miner's death:

> [The Miner's] early simple coal workers' pneumoconiosis was not a significant factor in leading to [the Miner's} demise. He had numerous medical problems, mostly involving his heart, but also his gastrointestinal tract.
>
> He was experiencing recurrent aspiration causing pneumonia; he had severe dementia; he had severe atherosclerotic cardiovascular disease; he had hypertensive cardiovascular disease; he had aortic vascular disease; he was throwing emboli to his brain; he was unable to swallow, he was having recurrent aspiration.
>
> Coal workers' pneumoconiosis was not a significant contributing factor to his demise nor did it hasten his demise.

(EX 6 at 30-31).

Treatment Records (DX 12, 21)

The most recent notes relate that the Miner was admitted to the hospital on August 22, 2003, for the following reasons: "Dehydration, poor appetite, increased confusion." The Miner was assessed with the following: "1) Dehydration secondary to poor intake; 2) Poor intake; 3) Advanced dementia with agitation; 4) Sub-therapeutic INR for status post aortic valve replacement; 5) Hyperlipidemia; 6) Osteoporosis with DJD and compression fracture; 7) History of CVA." His review of symptoms included "on and off shortness of breath, on and off coughing, positive for weight loss. Denies any chest pain. Positive for back pain. There is no history of leg swelling. No PND or orthopnea. Positive for agitations. Positive for confusion." The physical examination of his chest and lungs stated "He has a chest wall scar. Occasional dry crackles, both bases. He has severe kyphosis, thoracic. Equal chest expansion. There is no wheezing. Good air movement."

In notes dictated on November 15, 2003, two days before his death, Dr. Oculam related that the Miner was admitted to the hospital after having suffered a fall, from which he landed on his right side; "difficulty of breathing and shortness of breath was noted." The reasons for admission were listed as "1) Dehydration; 2) Failure to thrive; 3) Acute fracture of the ribs secondary to fall." Further, at the hospital, it was noted that "Patient had difficulty breathing. Because of this, he was admitted." Also, the review of symptoms state the following: "He has chronically been having difficulty with eating. Appetite is very poor and limited. He has frequent agitation and confusion. Confusion has been more severe. He is bed-bound most of the time. Positive for weight loss. No history of PND or orthopnea." Concerning the chest and lungs, the record states that "patient has noted limited inspiratory effort, positive air movement. There is no wheezing. He has chest wall scar from previous surgery. Severely kyphotic. He has some tenderness along the mid clavicular line, lower half of his anterior chest wall, right side."

Death Certificate (DX 9)

The death certificate was signed by Dr. Clarie Oculam[12] (DX 9). The immediate cause of death was listed as "failure to thrive;" the approximate interval between its onset and the Miner's death was two years. Dr. Oculam listed conditions leading to the immediate cause of death as "End stage dementia," the onset being one to two years before the Miner's death, and "multiple CVA." Finally, Dr. Oculam listed "Aortic valve replacement" as the underlying cause of death (DX 9).[13]

[12] The death certificate lists the certifier as Dr. Clarie Oculam. It appears, based on other representations in the file, that this physician is also the Claimant's treating physician, elsewhere referred to as Dr. Claire Occulam, and Dr. Claire Oculam (See DX 21 at 335, DX 20; see also Claimant's Brief).

[13] Included at DX 21, and discussed in the Claimant's brief, but not mentioned in the Miner's pre-hearing statement, is a questionnaire that Dr. Oculam completed on September 30, 2004 (DX 21 at 335). Dr. Oculam affirmed that the Miner had "a chronic lung disease that was caused by his coal mine employment;" specifically, he had both clinical and legal pneumoconiosis. She

Discussion

The evidence of record on cause of death consists of three physician opinions, the death certificate, and treatment records. The evidence does not point clearly in any one direction on the Miner's cause of death. Dr. Fino and Dr. Lockey opined that they could not conclude that the Miner's death was due to pneumoconiosis, and the death certificate did not list pneumoconiosis or any respiratory or pulmonary impairment as a cause of death. The remaining evidence, Dr. Perper's opinion, the treatment records, and Dr. Oculam's written statement, do not clearly illustrate that the Miner's death was due to pneumoconiosis, or any other respiratory impairment.

Dr. Perper opined that pneumoconiosis "ultimately contributed to and hastened [the Miner's] death," however, the reasons that he cited for the basis of his determination were all evidence that the Miner had pneumoconiosis or a respiratory or pulmonary impairment, and Dr. Perper did not link his respiratory impairments explicitly to his cause of death. Specifically, he based his findings on: the Miner's respiratory symptoms, such as shortness of breath, "objective pulmonary clinical findings," autopsy evidence of pneumoconiosis, and the presence of emphysema. These findings alone do not establish death due to pneumoconiosis, nor do they support such a finding when combined with statements made on the Miner's treatment records. While the hospitalization records immediately preceding the Miner's death do mention "difficulty of breathing and shortness of breath," the notes do not attribute these symptoms to any particular cause, such as a respiratory ailment. However, given that the Miner was admitted to the hospital after a fall in which he fractured his ribs, his shortness of breath would not be unexpected. Finally, while Dr. Oculam affirmed in her written statement, that "pneumoconiosis contributed to or played a hastening role in the miner's death," she did not state a basis for this opinion, which is particularly notable given that she signed the death certificate on which she did not cite either pneumoconiosis or any respiratory or pulmonary impairment as a factor in the Miner's death.

The Claimant alleged that the Miner had pneumoconiosis arising out of his coal mine employment, and that it contributed to his death. While she has established that the Miner had pneumoconiosis, she did not demonstrate that this pneumoconiosis "hastened" the Miner's death. The Claimant bears the burden of demonstrating such facts, and in this case, she did not meet that burden. Therefore, I find that she has failed to establish, by a preponderance of evidence that the Miner's death was due to pneumoconiosis.

IV. CONCLUSION

The Claimant has failed to establish, by a preponderance of evidence, all of the elements of entitlement. Therefore, her Claim must be denied.

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noted that the Miner was also a heavy smoker, and affirmed that she believed that the "pneumoconiosis contributed to or played a hastening role in the miner's death." She stated: "although we cannot discount the smoking habit, he does have X-ray findings in the past as per the record. Unfortunately, records were destroyed."

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VI. ORDER

The Claimant's Claim for benefits under the Act is DENIED.

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Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).